

REGULAR REVIEW

Child health statistical review, 1995

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This is the fourth in a series of review statistics pertaining to children. As before, the information is drawn mainly from routine data sources and include the latest currently available. This year the review includes information on childhood accident morbidity, measles, and immunisation and from the confidential enquiry into stillbirths and deaths in infancy (CESDI), as well as updating information from earlier reviews with respect to demography, mortality, morbidity, and social habits.

Demography**NUMBER OF BIRTHS**

There were 673 467 births in England and Wales in 1993, a crude birth rate of 13.1/1000 population, and 2% lower than the previous year (13.4/1000). The proportion of births occurring outside marriage continues to rise, but, as fig 1 shows, the fall in births among married couples is compensated by the rise among those for which there was joint registration, while single parent registration remains steady. Births that are jointly registered suggest that the infants are born to parents in a steady relationship. Nevertheless, estimates of the prevalence of one parent families in Great Britain show a sharper rise in single lone mothers than divorced/separated mothers over the last 10 years.¹ This suggests that even though the infants are jointly registered, they are more likely to be brought up in a lone parent household than those born to married parents.

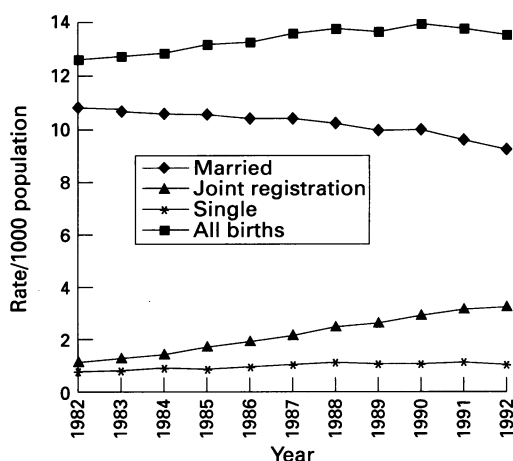


Figure 1 Birth rate by marital status of registrants, England and Wales, 1982-92 (source: OPCS FMI No 21).

MATERNAL AGE

The average age of women at delivery also rose slightly to 28.1 years (27.9 in 1992). This trend, of women delaying the start of their family, has been observed over several years. Table 1 shows that the cohort of women born in 1960 are twice as likely as women born in 1945 to have borne no children by age 30. Associated with this, there is a trend for smaller families: 12% of the 1945 birth cohort had four or more children compared with 10% of the 1950 cohort. However, there has been an increase in the fertility rate among women aged 40-44 years, with a rise from 4.4/1000 in 1983 to 5.9/1000 (1993).

MULTIPLE BIRTHS

The rate of multiple births/1000 maternities is shown in fig 2. The multiple birth rate increases consistently with maternal age except for the oldest group 40-44 years. Women aged 35-39 years are more than twice as likely to have a multiple birth than women aged under 20 years. There has been a steady increase in multiple birth rates to the older age groups of women; the fluctuation in the trend amongst the oldest age group is in part random variation associated with small numbers.

Table 1 Number of children by age and year of birth of woman, England and Wales

Age* and year of birth	No of children (%)				
	0	1	2	3	≥4
Age 20					
1945	74	18	6	1	0
1950	74	18	7	1	0
1955	77	16	6	1	0
1960	82	13	4	1	0
1965	84	12	3	1	0
1970	82	14	3	0	0
Age 25					
1945	34	26	27	9	4
1950	41	24	25	7	2
1955	49	22	22	6	2
1960	55	19	18	6	2
1965	60	18	15	5	2
Age 30					
1945	16	19	41	17	8
1950	22	19	39	14	5
1955	28	18	35	13	5
1960	34	17	29	14	6
Age 35					
1945	11	14	44	20	11
1950	16	14	43	19	9
1955	20	14	39	19	9
Age 40					
1945	10	14	43	21	12
1950	14	12	43	20	10

*Age in completed years. Source: OPCS, *Population Trends 70*, Winter 1992: 12 (reproduced with permission).

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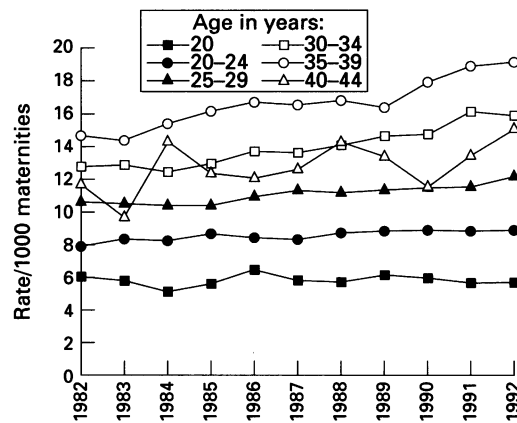


Figure 2 Multiple birth rate by maternal age, England and Wales, 1982-92 (source: OPCS FM1 No 21).

LIFE EXPECTANCY

Table 2 shows how the life expectancy of a child has improved in the last 30 years. Life expectancy calculations are based on the age at death of the population dying in any given year. The improvement in life expectancy at birth is 5.1 years (males) and 3.8 years (females), compared with the improvement of life expectancy at age 5 years of 4.7 years (males) and 3.7 years (females). The greater improvement in life expectancy among males is due to the reduction in male mortality during middle age, while the relatively greater improvement in the life expectancy at birth when compared with that at age 5 years relates to the improvement in infant mortality.

Mortality

INFANT MORTALITY

Although deaths in infancy have declined from 10/1000 live births in 1983 to 6.2/1000 live births in 1993, the level of risk of death experienced by infants is not seen again until after the age of 45 years. The variables on which data are routinely collected and which are known to be associated with risk of infant death are birth weight and region of residence of infant; and parity, social class, age, and place of birth of mother. About 80% of infant deaths occur before age 1 month.

CESDI, established in 1992, aims to identify ways in which these deaths might be prevented and the birth of a normal healthy baby assured for as many parents as possible.² It is a national system, a rapid reporting system for all deaths occurring from 20 weeks of

Table 2 Life expectancy for males and females, at birth and 5 years, 1961-90

Year	Male		Female	
	Birth	5 Years	Birth	5 Years
1961	67.9	64.9	73.8	70.4
1966	68.5	65.2	74.6	71.1
1971	68.8	65.3	75.0	71.4
1976	69.6	66.0	75.2	72.0
1981	70.8	66.9	76.8	72.8
1986	71.9	67.8	77.6	73.4
1987	72.2	68.0	77.9	73.6
1988	72.4	68.3	78.0	73.7
1989	72.7	68.5	78.3	73.9
1990	73.0	68.7	78.5	74.1

Source: OPCS, Population Trends 80, Summer 1995.

pregnancy to the end of the first year of life, and conducting confidential inquiries into a subset of the deaths identified. During 1993, deaths of normally formed infants weighing 2500 g or more, and dying within 144 hours (six complete days) of birth, where the death was possibly related to problems during labour, were the focus of a confidential inquiry. Since then, the types of deaths subject to a confidential inquiry has broadened and now includes all deaths to infants without apparent congenital abnormalities, weighing 1500 g or more, who died in labour or the first month of life. CESDI also carries out audit, both of its own function and as a coordinator of national projects. In addition, three health regions have supplemented the routine data collected by CESDI with further data, from both pathology and interviews with deceased parents, to investigate the aetiology of sudden infant deaths.²

During its first full year of operation, 1993, CESDI identified 8782 deaths and their causes. Variations are seen by age of mother (fig 3), with older women at increased risk of having an infants die before birth or as a result of immaturity or congenital malformation. This may be a consequence of aging, but may also represent repeated pregnancies in women with poor obstetric histories. Infants born to very young mothers (below 20 years) are at increased risk of death from accidents and infections, that is, non-obstetric related factors.

There are significant regional variations in mortality rates around the country, although rankings vary year-on-year, so caution is needed in the interpretation of such figures. Figure 4 illustrates, with confidence intervals, regional variation in death rates. Late fetal losses are pregnancies ending between 20 and 23 weeks' gestation, and CESDI are the only national reporting system to collect such information. Some of the regional variation may relate to under-reporting in this group. CESDI uses the 1992 definition of 'stillbirth' (fetal loss occurring on or after 24 weeks' gestation). Postneonatal death rates are most closely associated with socioeconomic factors, and the regional variations illustrate the 'north-south' divide, with lower death rates in the more affluent south, for example, Wessex region, and higher rates in the poorer north, for example, Northern region.

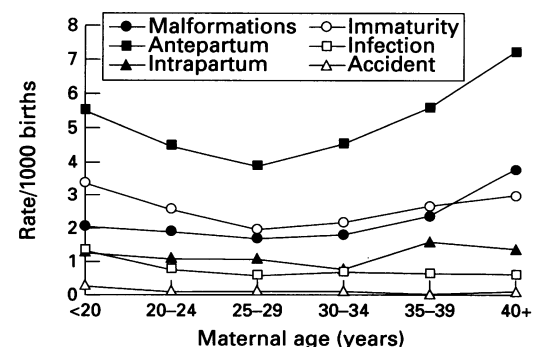


Figure 3 Maternal age specific death rates for six main causes of death identified by CESDI rapid reporting system, 1993 (source: CESDI annual report, 1993).

Figure 4 Regional variations (with 95% confidence intervals) in (A) late fetal losses (20–23 weeks' gestation), (B) stillbirths (24 weeks' gestation–term), (C) neonatal deaths (birth to age 28 days), and (D) postneonatal deaths (age 29 days to first birthday) (source: CESDI annual report, 1993).

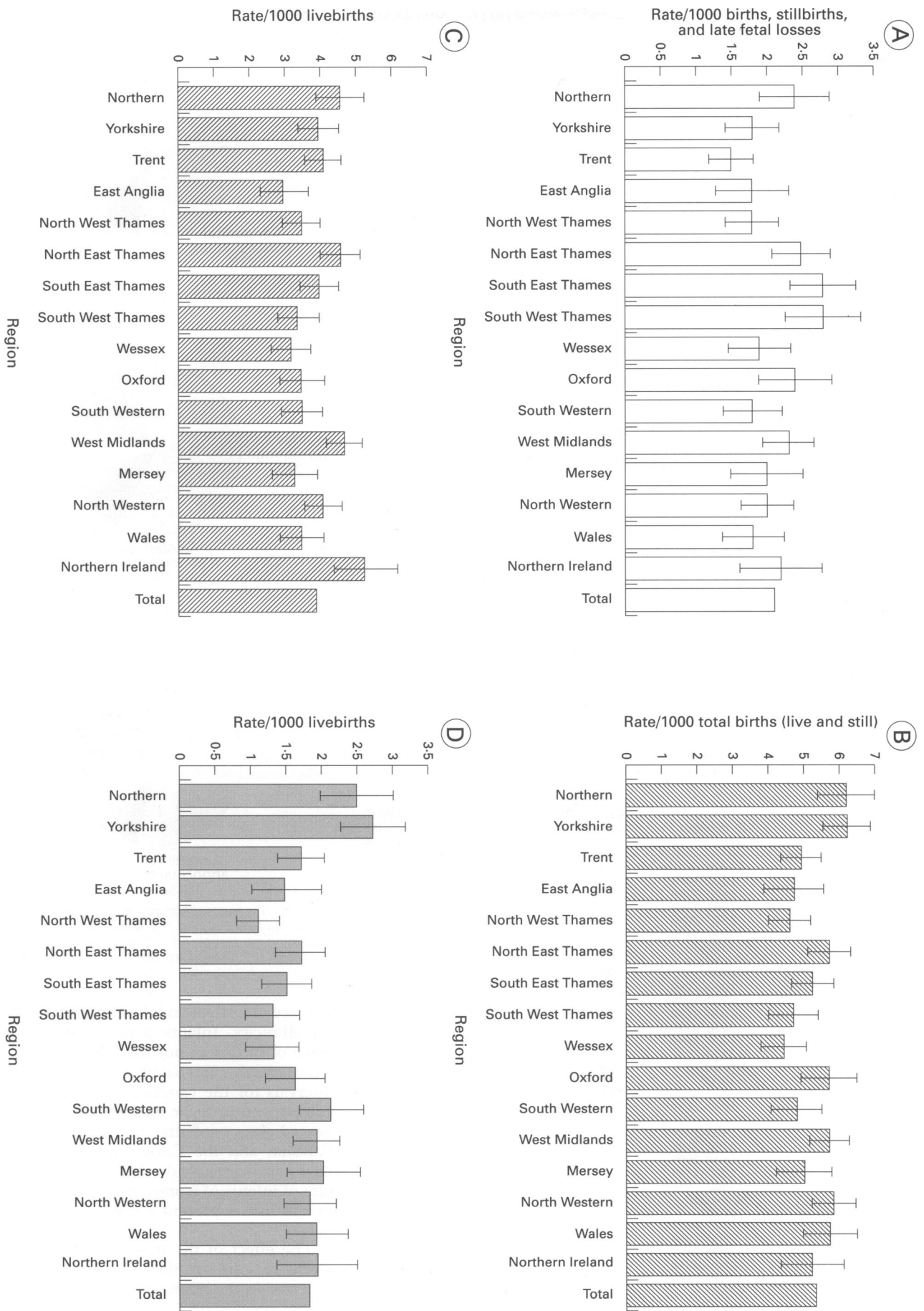


Table 3 Death rates for children under 1 year of age, by place of birth of mother, England and Wales (1993)

Place of birth of mother	Stillbirths (per 1000 live and stillbirths)	Neonatal (per 1000 live births)	Postneonatal (per 1000 live births)	Infant (per 1000 live births)
All	5.7	4.1	2.1	6.2
UK	5.4	4.0	2.0	6.0
New Commonwealth	8.0	5.8	3.2	8.9
Bangladesh	7.8	3.8	1.0*	4.8
India	5.7	4.1	3.3	7.4
Pakistan	10.0	7.7	5.1	12.7
East Africa	7.8	3.3*	3.7	7.0
Rest of Africa	10.9	7.7	2.2*	9.9
Caribbean Commonwealth	9.2	9.6	2.6*	12.2
Rest of Europe	6.9	4.3	2.8	7.0

*Based on fewer than 20 deaths. Source: OPCS Monitor DH3 95/1.

Table 4 Birthweight specific death rates, England and Wales (1983 and 1993)

Birth weight grouping (g)	Year	Stillbirths (per 1000 live and stillbirths)	Perinatal (per 1000 live and stillbirths)	Neonatal (per 1000 live births)	Postneonatal (per 1000 live births)	Infant (per 1000 live births)
<1500	1993	191.9	319.9	199.3	36.7	236.0
	1983	173.5	384.0	295.5	36.8	323.3
1500-1999	1993	44.2	59.5	20.9	9.4	30.2
	1983	69.0	106.9	46.6	18.7	65.3
2000-2499	1993	14.7	18.6	5.6	5.8	11.3
	1983	19.2	29.7	13.3	8.8	22.1
2500-2999	1993	4.1	5.5	2.0	2.5	4.5
	1983	4.9	7.5	3.7	5.2	8.9
3000-3499	1993	1.6	2.4	1.1	1.4	2.5
	1983	1.7	2.8	1.7	3.4	5.0
≥3500	1993	1.1	1.7	0.8	0.9	1.7
	1983	1.4	2.4	1.4	2.4	3.9
Not stated	1993	12.4	28.5	17.9	2.6	20.5
	1983	55.7	228.2	205.8	54.3	260.1
Total	1993	5.7	8.9	4.1	2.1	6.2
	1983	5.7	10.4	5.8	4.2	10.0

Source: OPCS Monitor DH3 95/1.

Table 5 Birthweight specific death rates, England and Wales and Sweden, 1990 (with 1993 England and Wales and Scotland figures for comparison)

Year	Country	Birth weight (g)	Stillbirths (per 1000 live and stillbirths)	Perinatal (per 1000 live and stillbirths)	Early neonatal (per 1000 live births)
1990	England and Wales	<1000	143.0	470.7	382.5
		1000-1499	108.8	196.7	68.3
		1500-1999	57.3	75.7	19.6
		2000-2499	15.0	19.5	4.6
		2500-2999	3.9	5.4	1.5
		3000-3499	1.7	2.5	0.8
		≥3500	1.2	1.8	0.6
	Sweden	<1000	109.7	401.3	327.5
		1000-1499	88.3	162.9	81.8
		1500-1999	54.1	76.7	24.0
		2000-2499	15.3	27.3	12.2
		2500-2999	5.2	7.9	2.7
		3000-3499	2.1	1.8	0.7
1993	England and Wales	Not stated	29.0	109.3	82.8
		<1000*	306.9 (129.8)	538.4 (420.4)	334.0
		1000-1499*	101.2 (86.6)	147.3 (133.6)	51.4
		1500-1999	44.2	59.5	16.0
		2000-2499	14.7	18.6	4.0
		2500-2999	4.1	5.5	1.4
		3000-3499	1.6	2.4	0.7
	Scotland†	≥3500	1.1	1.7	0.6
		Not stated	12.4	28.5	16.4
		<1000‡	386.6	590.1	331.8
		1000-1499‡	148.6	209.1	71.0
		1500-1999	54.6	78.7	25.4
		2000-2499	15.3	21.4	6.2
1993	Scotland†	2500-2999	5.7	8.2	2.5
		3000-3499	1.6	2.8	1.2
		≥3500	2.7	2.0	1.7
		Not stated	0.8	3.3	2.5

*Figures in parentheses indicate rates excluding stillbirths before 28 weeks' gestation.

†Provisional figures. ‡Stillbirth definition includes all losses from 24 weeks' gestation. Source: OPCS DH3 No 24, OPCS personal communication, Sweden: Socialstyrelsen Medicinsk Födelseregistrering, 1990, Information and Statistic Division, Scottish Health Service, Scottish Stillbirth and Neonatal Death Report, 1993.

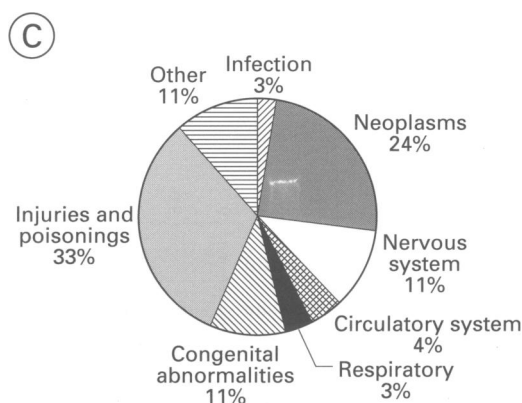
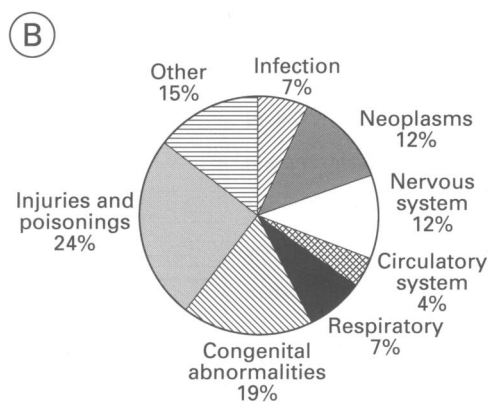
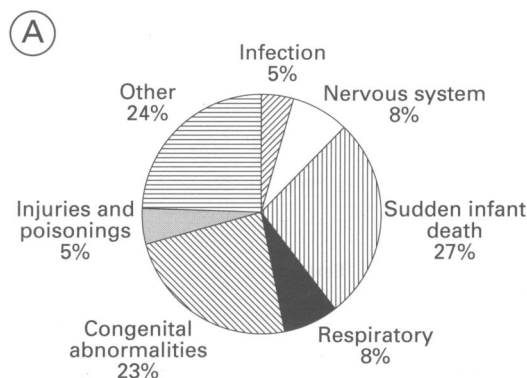


Figure 5 Pie charts illustrating main causes of death among children, England and Wales, by age group, 1992, in different age groups: (A) 28 days-1 year, (B) 1-4 years, and (C) 5-14 years (source: OPCS DH2 No 19).

Place of birth of an infant's mother is a proxy for ethnicity. Infants born to women whose place of birth was not the UK experience different death rates (table 3). The confidence intervals for the variations are wide, and any comparison must be interpreted with caution, nevertheless, infants of women born in Pakistan and the Caribbean Commonwealth have approximately double the infant mortality rate of infants of women born in the UK. This excess risk is present perinatally and postnatally.

The effect of the development of neonatal intensive care in the 10 years 1983-93 is reflected in the improvement seen in the birthweight specific neonatal death rates, shown in table 4, particularly among very low birthweight infants. Survival of infants weighing less than 1500 g has improved by a third, and infants born weighing less than 1500 g now

Table 6 Data relating to home and leisure accidents collected by HASS and LASS, 1993

	HASS		LASS	
	0-4 Years	5-14 Years	0-4 Years	5-14 Years
Estimated annual number	680 000	443 000	202 000	1 194 000
Proportion of population affected annually (%)	19.7	6.9	5.8	18.7
Inpatient stay (%)	4.5	3.1	3.1	3.1
Mean duration of stay (days)	2.3	2.7	2.1	3.1

Source: DTI, HASS. Report on 1993 accident data and safety research.

have a greater than 75% chance of surviving the first year of life. The survival of infants weighing less than 1000 g at birth is now a matter of interest. Data are not yet published routinely, but are available on application to the Office of Population Censuses and Surveys (OPCS) (see table 5). Care is needed in interpreting the change in stillbirth rates over the 10 year period, as the 1993 figures use the new (1992) definition of stillbirth (deaths in utero, on or after 24 weeks' gestation) while in 1983, the previous definition (deaths in utero on or after 28 weeks' gestation).

Table 5 shows an international comparison with Sweden for 1990, and highlights the greatly increased mortality risk for infants weighing less than 1000 g at birth. The difference seen between England and Wales and Sweden stillbirth rates in very low birthweight infants, is not seen mirrored in the early neonatal death rates suggesting that there maybe recording variations between the two countries. Table 5 also shows the 1993 figures for Scotland for comparison.

CHILDHOOD MORTALITY

In England and Wales in 1992, there were 5363 deaths among children aged less than 15 years, less than half of which (2408) occurred after age 28 days. Figure 5 illustrates the changing pattern of cause of death by age group; sudden death followed by congenital abnormalities are the most prevalent causes among postneonatal deaths. Injuries and poisonings are the most common cause of death among children over 1 year of age, particularly among those age 5-14 years where they account for a third of all deaths.

Morbidity

ACCIDENTS

The prevention of accidents in young people is a priority area identified by *The Health of the Nation*,³ and mortality from accidents was discussed in last year's statistical review.⁴ Many

Table 7 Commonest reasons for consulting GP for children age 0-15 years, 1991-2

Reason	Consultation rate/10 000 person years at risk
Intestinal infections	1157
Acute respiratory infections	7613
Disorders of ear and mastoid	3291
Ill defined conditions	2403
Chronic pulmonary disease (predominantly asthma)	1731
Inflammation of the skin	1668
Disorders of eye and adnexa	1257

Source: OPCS MB5 No 3.

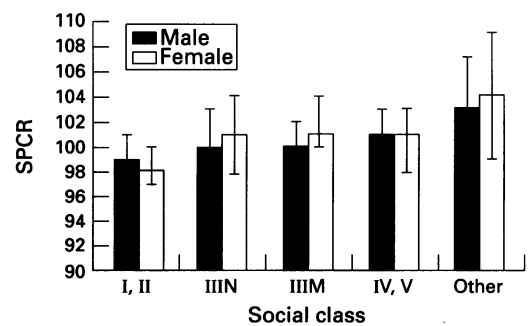


Figure 6 Age SPCR* for children 0-15 years by social class of parent, 1991-2 (source: OPCS MB5 No 3); *100=national average.

more children suffer disabilities from injuries after accidents, and the Consumer Safety Unit at the Department of Trade and Industry regularly collects data on the essential characteristics of home and leisure accidents, from a sample of hospitals throughout the UK.⁵ Accidents in the home are more common in children aged less than 5 years, and the home accident surveillance system (HASS) estimates that about one fifth of children of this age attend an accident and emergency department annually after an accident in the home (table 6), 4.5% of whom require inpatient admission. A third of these accidents are falls, often from stairs. Other major causes of home accidents in this group of children are hitting static objects (for example, tables), suspected poisonings, and burns. Among older children (age 5-14 years), leisure accidents are more common, and the leisure accident surveillance system (LASS) estimates nearly 19% attend accident and emergency departments after leisure accidents, with 3.1% requiring inpatient admission. The commonest mechanism for these accidents is again falls, but road traffic accidents are specifically excluded from these figures. Thus if a child falls from a bicycle while on the road, it is recorded by LASS, but if a car, or other road vehicle, is involved, it is not.

Both primary and secondary prevention measures are needed to reduce both the number and severity of accidents causing injury to children. Some falls, particularly in younger children, are a consequence of normal development, occurring when a child is

Table 8 Variation in GP consultations for children age 0-15 years, by social class, ethnic group, and single parent in household (odds ratios)

	Odds ratio	
	Male	Female
Ethnic group		
White	Reference group	
Black Afro-Caribbean	0.84	0.95
Indian subcontinent	1.46*	1.63*
Other	0.90	0.80
Social class		
I, II	Reference group	
III N	0.99	1.12*
III M	1.08*	1.15*
IV, V	1.08*	1.08
Other	0.91	0.93
Parents in household		
Both	Reference group	
Single	1.01	1.11*

*Significant at $p < 0.05$. Source: OPCS MB5 No 3.

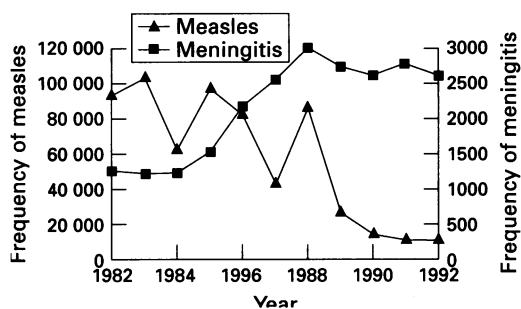


Figure 7 Frequency of reporting of measles and meningitis, England and Wales, 1982-92 (source: OPCS MB2 No 17).

exploring his environment; it is important that this environment is safe and that serious consequences of normal play are avoided. Among older children, supervision and education can reduce the incidence of accidents, while measures such as cycle helmets can reduce the severity of the consequences of any fall.

GENERAL PRACTITIONER CONSULTATIONS

Data from the fourth national survey of morbidity in general practice (1991-2), estimate that children aged 0-4 years are seen by their general practitioner (GP) about four times a year, and older children (5-15 years), about twice a year. Approximately 8% of these GP contacts take place in the child's home. Less than 10% of consultations are for serious (potentially life threatening conditions), a smaller proportion than at any other age. Table 7 summarises the reasons for the consultations; acute respiratory infections are the commonest reason for a child to see the GP. An age standardised patient consulting ratio (SPCR) of 100 is the national average; fig 6 shows that

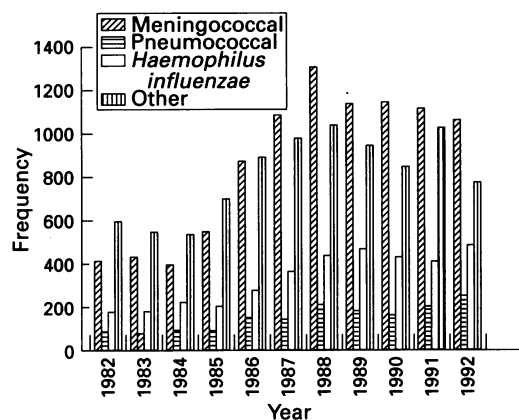


Figure 8 Reported aetiology of meningitis cases, England and Wales, 1982-92 (source: OPCS MB2 No 19).

Table 9 Congenital malformations 1992; rate/10 000 live and stillbirths, by sex, England and Wales

Condition (ICD number)	Liveborn		Stillborn	
	Male	Female	Male	Female
All conditions	96.1	72.1	476.2	380.9
Central nervous system defects (740-742)	3.6	4.0	135.2	187.0
Cleft lip/palate (749.0-749.2)	11.5	9.1	47.1	20.8
Abnormalities of external genital organs (752, 778.6)	17.7	1.3	17.6	6.9
Chromosomal abnormalities (758)	6.9	7.3	58.8	48.5

Source: OPCS MB3 No 8.

it varies by social class of parent, with the highest rate of consultations occurring among children for whom social class of head of household could not be assigned (category 'other'), for example, where the head of the household was unemployed or a housewife. Odds ratios for consulting rates are shown in table 8. These can be interpreted to show that children from the families from the Indian sub-continent were approximately 50% more likely to consult their GP than children from white families. In contrast, children from Afro-Caribbean families were less likely to consult their GP than white children, but the difference was not statistically significant. Male children from the households of manual workers were 8% more likely to consult their GP than children from non-manual households, and the female children of single parent households consulted the GP 11% more frequently than those from two parent households.

COMMUNICABLE DISEASES

Figure 7 shows the number of reported cases of measles over the last 10 years, and illustrates the cyclical nature of the epidemics, with peaks every 2-3 years persisting throughout the 1980s. Measles, mumps, and rubella immunisation was introduced in 1988, and since then no further peaks have been observed. The incidence has fallen further since with the measles/rubella campaign in November 1994. This campaign reached 90% of the targeted 7.1 million children aged 5-16 years.⁶ There were only 35 cases of measles reported in the first four months of 1995 (only two of which occurred in children covered by the immunisation campaign⁷) compared with over 100 cases in November and December 1994.⁶

Meningitis continues to excite coverage by the media. The number of reported cases has increased in the last 10 years (fig 7), reaching a peak in 1988, and declining only slightly since then. Figure 8 shows the reported cases according to aetiology over the same time period. The most important contribution to the rise have been meningococcal and *Haemophilus influenzae* infections. The incidence of the latter is now expected to decline after the introduction of immunisation in October 1992. The highest age specific notification rates occur in children aged less than 4 years.⁸

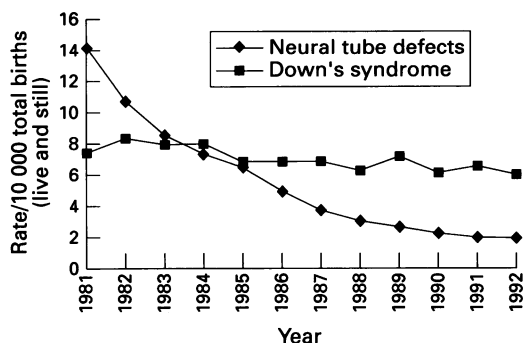


Figure 9 Changes in reported prevalence of neural tube defects and Down's syndrome, England and Wales, 1981-92 (source: OPCS MB3 No 7).

Table 10 Use of alcohol and cigarettes among young people (%)

	Year 4 (8-9)		Year 5 (9-10)		Year 6 (10-11)		Year 7 (11-12)		Year 8 (12-13)		Year 9 (13-14)		Year 10 (14-15)		Year 11 (15-16)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Never smoked	91.9	93.0	88.9	91.6	82.8	86.9	73.3	77.5	65.0	44.1	52.1	44.1	42.5	36.1	39.6	31.7
Smoked in previous week	1.5	1.3	1.7	0.5	1.2	1.0	4.3	4.2	6.1	7.8	12.8	17.5	19.3	25.5	29.2	29.5
Drank alcohol in previous week	23.6	17.5	26.6	16.4	32.8	18.6	27.2	17.0	35.3	30.3	44.6	40.0	57.1	54.1	65.9	60.2

Source: School Health Education Unit, University of Exeter.^{10,11}

Table 11 Drug use among young people (%)

Drugs	Year 7 (11-12)		Year 8 (12-13)		Year 9 (13-14)		Year 10 (14-15)		Year 11 (15-16)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Amphetamines	0.6	0.4	1.4	0.8	4.0	2.8	6.6	5.4	10.7	9.6
Barbiturates	0.2	0.0	0.3	0.1	1.3	0.8	1.3	0.9	2.2	1.2
Cannabis	1.1	0.2	2.7	1.5	10.4	6.6	17.5	14.7	28.1	21.7
Ecstasy	0.2	0.5	1.2	0.9	2.1	1.6	3.2	2.0	5.7	3.0
Cocaine	0.1	0.0	0.6	0.4	0.7	0.6	1.4	0.9	1.0	1.3
Natural hallucinogens	1.0	0.1	2.0	1.1	4.8	2.9	7.2	3.6	10.1	6.3
Synthetic hallucinogens	0.6	0.2	1.8	0.8	4.9	3.3	8.0	5.9	12.9	8.6
Heroin	0.2	0.2	0.4	0.1	0.4	0.3	1.0	0.5	1.1	0.5
Crack	0.4	0.2	0.3	0.1	0.8	0.4	0.8	0.6	1.0	0.7
Solvents	0.6	0.3	1.8	1.7	4.1	3.2	5.1	5.0	5.4	6.9
Tranquillisers	0.2	0.2	0.5	0.4	1.3	1.0	1.5	1.3	1.7	1.5
Other	0.3	0.2	0.2	0.3	0.6	0.4	0.6	0.6	0.6	0.4
None	96.2	98.2	93.4	94.8	83.8	86.3	75.7	77.7	65.3	72.0

Source: School Health Education Unit, University of Exeter.^{10,11}

CONGENITAL MALFORMATIONS

There were 6096 congenital malformations notified to OPCS during 1992 (table 9). The notification rate is 34% higher in males, 58% of which are due to abnormalities of the external genitalia. As notification is voluntary, and only malformations detected within 10 days of birth are reportable, there is potential for under-reporting of all congenital abnormalities, and differential under-reporting for some conditions, for example, malformations of heart and circulatory systems.

Figure 9 shows that the reported prevalence of neural tube defects has fallen by 76% in the 10 years to 1991. This fall has been reported in other countries, including Canada, Australia, and the Netherlands.⁹ The fall in the birth prevalence of Down's syndrome over the same period has been much smaller, although with the recent widespread introduction for screening for Down's syndrome ('triple test'), this decline may accelerate in future years.

Social habits

SMOKING

The Health of the Nation specified a fall of 33% to less than 6% as a target for the reduction in smoking prevalence in 11-15 year olds.³ The Schools Health Education Unit at Exeter University has, annually since 1986, examined health related behaviours in young people.^{10,11} Table 10 shows that in 1993, the prevalence of

smoking (in the week before questioning) reported by young people aged 12 years was in excess of 6%, rising to nearly 30% in 15-16 year olds. At all ages, females reported higher smoking prevalence. Smoking starts at an early age, with 8% of 8-9 year olds reporting smoking on at least one occasion (1991-2 data), and by age 16, only 39% of males, and 32% of females report never smoking.

ALCOHOL

Over 60% of 15-16 year olds reported consuming an alcoholic drink in the week before the questioning. Males at all ages are more likely to report recent alcohol consumption, with 24% of 8-9 year olds compared with 17.5% of females (1991-2 data), and rising to 66% of males age 15-16 years compared with 60% of females of the same age. This high prevalence of alcohol use is a matter for concern as both alcohol related illness and crime have risen in the last 10 years.

DRUG USE

Use of illegal substances is an increasing problem among young people in the UK. Table 12 shows the reported ever use of drugs among young people aged 11-16 years, from the Schools Health Education Unit at Exeter University. Cannabis is the most widely used drug, with almost 28% of males and 22% of females age 15-16 years reporting ever use. In contrast, 72% of females and 65% of males have never taken any of the drugs listed in table 11.

Table 12 Targets identified in *The Health of the Nation* directly aimed at children

HIV/AIDS and sexual health

To reduce by at least 50% the rate of conceptions among those under 16 years by the year 2000 (baseline 1989)

Accidents

To reduce the death rate from accidents among those under 15 years by at least 33% by 2005 (baseline 1990)

Smoking

To reduce smoking prevalence of those 11-15 years by at least 33% by 1994 to less than 6% (baseline 1988)

A child born in Britain in the 1990s, provided it survives the first year of life, can expect to survive until the age of 73 years (males) or 78 years (females). The greatest risks to the health of young people come from injury and from their lifestyles, rather than illness, and several of the targets identified by *The Health of the*

*Nation*³ are specifically aimed at young people (table 12). Cigarette smoking, in particular, is associated with several major causes of mortality, yet the prevalence of smoking in young people is not falling. Adolescent health, for so long a grey area between child and adult health services is beginning to be recognised as a speciality in its own right, and was an area of focus of the chief medical officer's report in 1993.¹² More recently, the government has launched a new initiative aimed at the health of young people *The Health of the Young Nation*, and specific targets will be published shortly, most aimed at young people age 10–19 years, but some at younger age groups. This initiative aims to bring immediate benefits to young people's health, to avoid long term harm and to establish healthy lifestyles to carry them through to adulthood, to provide long term health benefits, both to themselves and their children.

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